8848 September Way, Lincoln De, 19960 302-491-6946

Today's Date: __________

Client Name: ____ Date of Birth: _______________

Address: ____

____

Home Phone: ______________ Cell Phone: _____________________Work Phone: _______________________

Email: ____

Parent/ Guardian Name and contact info if different: ____

Emergency Contact Name and Number____

Who may we thank for referring you to Courageous Hearts LLC?

____

All sessions are for 45-60 minutes. This is the standard session length. If you have a change in insurance while you are in treatment, please let us know immediately so that we can avoid any billing confusion.
If your insurance lapses and we have sessions that are not covered by insurance, you will be responsible for payment of the full session fee ($175.00/office; $250.00/Equine Assisted Psychotherapy). So, let's work together to prevent this from occurring!

It is our goal to provide therapeutic services that meet or exceed your expectations. If for any reason you want to discuss the financial component of treatment, please let me know.

Thank you for allowing us to assist you. We are glad to be a part of your life's journey!

Sincerely,

Rosemary Baughman LCSW, CADC, EAP advanced certified
Director

I have read, understand and agree to the above: ________________________________ ____________
Responsible Parties Signature **DATE**

Updated 1/2024

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Cancellation Policy

At Courageous Hearts LLC, your healing and therapeutic process is our top priority. We are glad you have chosen to care for yourself by choosing therapy with our agency. We have found that treatment is most effective with consistent, regular attendance.

When your session is scheduled, we set aside time just for you, and we will make preparations in order to assist you in your emotional growth and healing process. It is essential that if you need to change or cancel your session, you contact us **AT LEAST 24 HOURS** in advance. There will be a **$100.00 charge for NO SHOWS or Cancellations within less than 24 hours**. This is expected to be paid before we will reschedule. However, we understand that emergencies do occur and will make exceptions on a case-by-case basis.

Note: remembering your scheduled session is your responsibility, we do not have staff that make reminder calls.

We appreciate your cooperation. We look forward to working with you to reach your therapeutic goals.

_____________________________ _______________

PARTICIPANT DATE

_____________________________ _______________

GUARDIAN DATE

_____________________________ _______________

Courageous Hearts LLC STAFF DATE

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Office/Farm Policy

Dear Clients and families,

We welcome you to Courageous Hearts LLC, located at Little Bit Acres.

We already anticipate that it will be a pleasure working with you. Please take a few minutes to review these farm policies so that you are fully aware of expectations at the farm.

We attempt to maintain a casual environment and hope clients feel comfortable in this natural setting. The services you receive may occur in the office, barn, pasture, or arena. It is recommended that you dress accordingly. Equine-assisted psychotherapy (EAP) is not about riding or horsemanship, and no specific clothing is required for participants. However, we insist that you wear closed-toe shoes such as sneakers, boots, or other casual shoes (no sandals, flip-flops, or croc-type shoes) to protect your feet while near horses.

If you have no horse experience, you are PERFECT for EAP services. The activities you will participate in require NO horse knowledge. We will provide tips before beginning services to make your experience safe and beneficial for you and the horses.

We have additional animals on the property whom you are welcome to interact with in a respectful manner

Please keep in mind that the safety and privacy of all clients is important and for that to occur,* ***hours at the farm are by appointment only. *Please do not visit other than your scheduled time***

We know that clients frequently have such a wonderful experience at Courageous Hearts that they want to share this with others. If you know anyone who may benefit from our services, you are welcome to give them our contact information and speak with them about their own appointment. We adhere to strict confidentiality policies and will not share information with others.

We request you keep your scheduled appointment, as we will have prepared activities designed for your experience. Please check in upon arrival so that we can share time with you. **Remember that clients are not permitted in the barn, pasture, or arena without one of the professionals on site.**

We look forward to meeting and sharing experiences with you at Courageous Hearts…*Where Horses Empower People.*

Sincerely,

Executive Director, Rosemary Baughman LCSW, CADC

____________________________________ ____________________

Client Signature Date

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LIABILITY RELEASE FORM

I acknowledge that all therapeutic and learning activities involving horses entail known and unanticipated risks, which could result in physical or emotional injury, paralysis, death or damage to me, to property or to third parties. I understand that such risks cannot be eliminated without jeopardizing the essential qualities of the activity.

I expressly agree and promise to accept and assume all the risks existing in these activities. My participation in these activities is purely voluntary, and I elect to participate despite the risks.

I certify that I have adequate insurance to cover any injury or damage I may cause or suffer while participating in these activities or on the premises at Little Bit Acres. I also agree to bear the costs of such injuries or damage to myself. I certify that I have no medical or physical conditions that would interfere with my safety in these activities, or else I am willing to assume and bear the cost of- all risks that might be created, directly or indirectly, by any such condition.

I agree to hold harmless and indemnify Courageous Hearts LLC, Compassionate Hearts Inc., Little Bit Acres, all owners, employees, contractors and subcontractors to Courageous Hearts LLC and Compassionate Hearts Inc. and release them from any liability or responsibility for accident, damage, injury, illness or death to undersigned or any family members or spectator accompanying the undersigned.

WARNING
Under Delaware Law, an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to 10 Delaware Code Section 8140.

The signature below indicates receipt of this release and full knowledge of its contents.

___________________________________ _________________

Signature of participant **Date**

____________________________________ _________________

Signature of parent or guardian **Date**

__________________________________ _________________

Courageous Hearts Staff **Date**

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CONSENT FOR TREATMENT

I/We, the undersigned, hereby consent to participate in treatment with Courageous Hearts LLC.
AND/OR
I/We are the parent/s or legal custodial guardians of the minor child/children listed below and give consent to Courageous Hearts LLC to provide services for:

_____________________________ __________

Client's name Date of Birth

I/We understand that treatment is in accordance with the Statement of Patient Rights and that State and Federal regulations regarding the confidentiality of patient records protect all records of Courageous Hearts.

I/We understand that payment for services are expected when services are received.

I/We understand that I/we have the right to refuse any treatment or therapy offered by Courageous Hearts LLC Equine Assisted Psychotherapy and Learning Center.

I/We understand that I/we may revoke this consent at any time by oral and/or written request.

***I/We understand that on occasion, an undergraduate or graduate student may be present in session for their learning experience and agree _______________**
Client or guardian initial

***I/We understand that treatment may be administered by a masters level mental health intern receiving supervision by a Licensed Clinical Social Worker. __________**
Client or guardian initials

I/We have read and understand the above:

CLIENT SIGNATURE___________________________________ DATE: __________

PARENT/ Guardian SIGNATURE ___________________________________ DATE: _________

STAFF SIGNATURE ___________________________________ DATE: _________

Updated 1/2024

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CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, ____

ON BEHALF OF: ______________________________DOB:____________

Consent to and authorize Courageous Hearts Equine Assisted Psychotherapy and Learning Center to:
Receive from: yes no **Release** to: yes no

____
Name of person or entity phone/address

The following information related to my treatment with Courageous Hearts LLC:
PLEASE CIRCLE EITHER YES OR NO FOR EACH ITEM:

Enrollment	yes	no	Medications	yes	no
Lab Results	yes	no	Assessment	yes	no
Diagnosis	yes	no	Treatment Plan	yes	no
Progress Reports	yes	no	Status/Attendance	yes	no
Discharge Information	yes	no	Substance Abuse	yes	no

Note: Federal and Delaware laws protect the release of Substance Abuse, HIV, or other health-related information (Ref:42 CFR, 45 CFR, DE title 16)
Specify any limitations on release or other information you like to have released:
____

This information will be used only for any of the following reasons and only the person or entity named above has my consent to:

- Coordinate treatment
- Plan for & provide referral, assessment, ongoing treatment or services, and/or medical care
- To obtain insurance, employment, social services or government benefits
- To coordinate treatment or services with my family or other concerned individuals listed above.

I understand that by law, I do not need to consent to this release of information. I do so willingly and voluntarily for the purpose(s) specified above. I can withdraw this consent at any time except to the extent that the information has already been released. I understand that I am entitled to a copy of this document in completed form. This form has been explained to me and I understand its contents.
THIS CONSENT IS GOOD FOR ONE YEAR OR 30 DAYS AFTER I AM DISCHARGED FROM TREATMENT, WHICHEVER IS EARLIER.

Client Signature: __________________________ Date: ______________

Guardian Signature: ________________________ Date: _______________

Witnessed by: ________________________ Date: _______________

Please direct all inquiries and replies to:

Courageous Hearts LLC
8848 September Way, Lincoln DE 19960
Office.courageous@gmail.com

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HIPAA Acknowledgement

By signing below, I acknowledge that I have **been offered a copy** of this office's Notice of Privacy Practices form.

_______________________________________ _________________

Client/ Parent/Guardian Signature Date

Refusal to Sign Acknowledgment

_______________________________________ _________________

Client/ Parent/Guardian Signature Date

Notice of Privacy Practices was sent

_______________________________________ _________________

Client/ Parent/Guardian Signature Date

_________________ ______________

CH staff initials Date

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Need copy of the Insurance card both front and back

PATIENT INFORMATION: (Please Print) **Provider name** ______________________________

Patient Name:

____

(Last) (First) (Middle Initial)

Home Address: ____ **Apt#** _______

____

City State Zip Code

Mailing Address if different then Home Address: ___________________________________ **Apt#** _______

____

City State Zip Code

Home Phone #: _____-_____-_______ **Cell Phone #:** _____-_____-_______ **Sex:** ☐ Male ☐ Female

Date of Birth: _____/_____/_____ **Social Security Number:** ______-______-________

Month Day Year

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐ Partner

Referring Physician if applicable: _______________________ **Referring Physician Phone#:** _____-____-______

INSURANCE INFORMATION:

Primary Insurance Company: ___________________ **ID Policy #:** _________________ **Group #:**__________

Claims Address: ____ **Phone #:** _____-_______-_______

Policy holder's Name: ____ **Date of Birth:** ____/____/______

Month Day Year

Social Security #: ____________________________ **Effective Date of Insurance:** ______/______/_______

Month Day Year

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Person Responsible for Account: ☐ Patient ☐ Parent ☐ Other

______________________________ Date of Birth: ____/____/______ Phone # _____-_______-______

Name (if different from patient)

****

Secondary Insurance _______________________________________ **ID Policy #** ____________________

Claims Address: ____ **Phone #:** _____-_______-______

Policy holder's Name: ____ **Date of Birth:** ____/____/______

AUTHORIZATION TO BILL INSURANCE:

Patient or Authorized person's signature: I authorize Every Penny Counts to submit claims on my behalf. I authorize the release of any medical or other information necessary to process my claims.

Signed ____ Date______________